MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01401

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH COUNTY: Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville
LENGTH OF STAY (in this place): 3 - 11
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Pr. George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fanham
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): Edgar (First) Jacob (Middle) Adams (Last)
4. DATE OF DEATH: Feb (Month) 4 (Day) 1950 (Year)
5. SEX: Male
6. COLOR, OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1905
9. AGE last birthday: 45 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Maker
10b. KIND OF BUSINESS OR INDUSTRY: Steel
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edgar J. Adams
14. MOTHER'S MAIDEN NAME: Essie Malone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT AND ADDRESS: Hospital records Sykesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Tuberculosis bilat. fibrotic	Indef
Antecedent cause(s)	(b) Mitral Heart Disease	"
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Syphilis, systemic	"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Schizophrenia, paranoid	"

002X 13b

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 25, 1946, to Feb 4, 1950, that I last saw the deceased alive on Feb 4, 1950, and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE: Henry C.A. Mead M.D. (Degree or title) ADDRESS: Sykesville, Md. DATE SIGNED: 2/4/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 2-7-50
NAME OF CEMETERY OR CREMATORY: Cedar Hill
LOCATION (City, town, or county) (State): Prince George County

DATE REC'D BY LOCAL REG.: Feb. 5, 1950
REGISTRAR'S SIGNATURE: C. Harry Heer
24. FUNERAL DIRECTOR: W. W. Chamber. ADDRESS: 517-11 st. S.E.

OK Dr. M. 029

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

30429

RECEIVED
FEB 7 1950
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01402

Reg. Dist. No. 74

BC

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1mo. 30 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 5
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location): 812 N. Bond St.,

3. NAME OF DECEASED (Type or Print)	(First) ANNIE	(Middle) BELL	(Last) AMBLER	4. DATE OF DEATH	(Month) Feb., (Day) 15 (Year) 1950
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Sep.,	8. DATE OF BIRTH: Feb., 16, 1928	9. AGE last birthday: 21 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Perry, Georgia	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: John H. Bishop		14. MOTHER'S MAIDEN NAME: Mattie Perkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 254-34-6936	17. INFORMANT AND ADDRESS: Deceased			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002 Immediate cause (a) Pulmonary Tuberculosis — June, 1949

Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 16, 1949, to Feb., 15, 1950, that I last saw the deceased alive on Feb., 15, 1950, and that death occurred at 10:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	2/15/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 19-50	Mt Calvery Cem.	Brooklyn A.A. Co. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/15/50	Albert R. Swankhaus	Elroy O. Wilson	1000 Brantly ave

Deputy Local

52096

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01403

CERTIFICATE OF DEATH

Reg. Dist. No. 77

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead | LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) E (Last) ARMACOST
4. DATE OF DEATH: (Month) Feb (Day) 15 (Year) 1950
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr 7 1880
9. AGE last birthday: 69 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Building const.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H Armacost
14. MOTHER'S MAIDEN NAME: Martha Bush
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 217-12-7147
17. INFORMANT: Mrs Leone Ledmatte

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause	(a) Cerebral Embolism	2 Days
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mural Thrombosis	1 week
	(c) Coronary Occlusion	2 wks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 23, 19 48, to Feb 15, 19 50, that I last saw the deceased alive on Feb 15, 19 50, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Joseph E Bush	M D	Hampstead Md	2-16-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb 18/50	St Pauls	Owings Balto Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 17, 1950	John Hughes Jr.	Edw C Tipton	Hampstead Md

3054

RECEIVED
FEB 20 1950
BUREAU V. S.

01404

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

BC Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Airey — LENGTH OF STAY (in this place) 5 MO	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Blissard Boarding Home	STREET ADDRESS (If rural, give location) 2304 Calverton Hgts. Ave. ✓

3. NAME OF DECEASED (Type or Print) (First) Caroline (Middle) (Carrie) (Last) Barford

4. DATE OF DEATH (Month) Feb (Day) 17 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F M	White	Widowed	10/8/1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home	Home	Saleen Co. Mo.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	NO	NO	Mr. Geo. Barford 908 Poplar Grove St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X Immediate cause (a) Cerebral Hemorrhage — 5 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis — yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 9, 19....., to Feb 17 1950, that I last saw the deceased alive on Feb 16, 1950, and that death occurred at 7 30 a m., from the causes and on the date stated above.

SIGNATURE C. McLean Poole (Degree or title) MD ADDRESS Mt Airy Md DATE SIGNED 2/17

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/20/50	Woodlawn	Woodlawn Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
2/17/50	H. W. Hedrick DM	John T. Stansbury 2700 Edmondson Av.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01405

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: D Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 1yr. 10mos. 24days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 5
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL	STREET ADDRESS (If rural, give location): 837 N. Washington St., ✓

3. NAME OF DECEASED (Type or Print)	(First) OLLIE	(Middle)	(Last) BEDFORD	4. DATE OF DEATH	(Month) Feb.,	(Day) 23	(Year) 1950
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Dec., 2, 1900	9. AGE last birthday: 49 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mold Man Leader	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Homer, Louisiana	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Robert Bedford	14. MOTHER'S MAIDEN NAME: Savannah Thomas						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 212-01-9131	17. INFORMANT AND ADDRESS: Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — Jan., 1948

002 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

13b (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 29, 1948, to Feb., 23, 1950, that I last saw the deceased alive on Feb., 23, 1950, and that death occurred at 9:05 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton, Maryland	2/23/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/27/50	Mt. Calvary cem.	Anne Arundel County - Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/23/50	Albert R. Swanhorn	Mrs Robt. Elliott Daughter	1129 N. Caroline St.

Deputy Local

316 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

RECEIVED
FEB 28 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01406

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (In this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Liberty Rd near Sykesville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
STREET ADDRESS (If rural give location) Liberty Road

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Lewis (Last) Bollinger
4. DATE OF DEATH: (Month) Feb (Day) 22 (Year) 1950

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M
8. DATE OF BIRTH: Dec 23 1876
9. AGE last birthday: 73 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Owner
10b. KIND OF BUSINESS OR INDUSTRY: Grist Mill
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Elias Bollinger
14. MOTHER'S MAIDEN NAME: Magdalena Braunning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Mary A. Bollinger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage

331 / 330 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/20, 1950, to 2/22, 1950, that I last saw the deceased alive on 2/22, 1950, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Wm E. Martin, M.D. Randallstown Md

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Feb 25 1950 | NAME OF CEMETERY OR CREMATORY: Trinity Lutheran Cem | LOCATION (City, town, or county) (State): Reisterstown Md

DATE REC'D BY LOCAL REG. 2/22/50 | REGISTRAR'S SIGNATURE: Wm. E. Martin, C. Harry Weer

24. FUNERAL DIRECTOR: Wm Berryman & Sons-Reisterstown Md — ADDRESS

384 X 4

VS. A15

RECEIVED
MAR 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01407

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeville — LENGTH OF STAY (in this place): 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ridgeville
STREET ADDRESS (If rural, give location): R.D. Mt. Airy

3. NAME OF DECEASED (Type or Print): (First) TILLIE (Middle) (Last) BRANDENBURG

4. DATE OF DEATH: (Month) Feb (Day) 1 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 8-5-1870

9. AGE last birthday: 79 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: M. Luther Renn

14. MOTHER'S MAIDEN NAME: Annie Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Carl D. Brandenburg, Mt. Airy, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 X **Immediate cause** (a) Cerebral Hemorrhage — 4 hrs

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension and Arthritis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1950, to Feb 1, 1950, that I last saw the deceased alive on Jan 30 1950, and that death occurred at 2 9 m., from the causes and on the date stated above.

SIGNATURE: C M Van Fossen (Degree or title) — ADDRESS: Mt Airy Md — DATE SIGNED: Feb 1 1950

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 2-3-1950 — NAME OF CEMETERY OR CREMATORY: Pine Grove — LOCATION (City, town, or county) (State): Mt. Airy, Md.

DATE REC'D BY LOCAL REG. Feb 2/50 — REGISTRAR'S SIGNATURE: Thos D Snyder

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz, Winfield, Md.

RECEIVED
FEB 6 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01408

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
LENGTH OF STAY (in this place) 88 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Manchester Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Westminster
STREET ADDRESS (If rural give location) Manchester Road, RD#4

3. NAME OF DECEASED (Type or Print) (First) JACOB (Middle) — (Last) BREHM

4. DATE OF DEATH (Month) Feby (Day) 5 (Year) 1950

5. SEX M.
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH Nov 14 1861
9. AGE last birthday 88 yrs. If under 1 year Months Days If under Hours 24 hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Brehm Sr.
14. MOTHER'S MAIDEN NAME Eva Basler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Elmer C. Brehm, Westminster Md RD#4

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) acute cardiac decompensation	40 hrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes Mellitus	20 yrs
	(c) arteriosclerosis	10 yrs

260 X

61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 29, 1950, to Feby 5, 1950, that I last saw the deceased alive on Feby 5, 1950 and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE Chas. R Foutz M.D. (Degree or title) ADDRESS Westminster, Md DATE SIGNED Feby. 6. 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2/8/50
NAME OF CEMETERY OR CREMATORY Leister's Cemetery
LOCATION (City, town, or county) Rural Westminster Md (State)

DATE REC'D BY LOCAL REG. 2/7/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md. ADDRESS

000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 9 1950
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01409

CERTIFICATE OF DEATH

BC Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (In this place): 9 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural give location): unknown ✓

3. NAME OF DECEASED (Type or Print) (First) Emma	(Middle) J.	(Last) Bryan	4. DATE OF DEATH (Month) Febr.	(Day) 7	(Year) 1950
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: June 20, 1867	9. AGE last birthday: 82 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school teacher	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13. FATHER'S NAME: Thomas Alfred Bryan		14. MOTHER'S MAIDEN NAME: Emily Higgins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Hospital records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
332X Immediate cause	(a) Cerebral thrombosis	about	2 months
Antecedent cause(s) 83b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral arteriosclerosis	known	9 years
	(c) ~~Schizophrenia, paranoid type~~	~~known~~	~~49 years~~
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Schizophrenia, paranoid type	about	49 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 47, 19....., to Febr. 7, 1950, that I last saw the deceased alive on Febr. 6, 1950, and that death occurred at 12 45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Elizabeth A Niniary Springfield St H. Sykesville Md Febr. 7. 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 2/9/1950	NAME OF CEMETERY OR CREMATORY: New Cathedral	LOCATION (City, town, or county) (State): Balto Md
DATE REC'D BY LOCAL REG.: 2/8/50	REGISTRAR'S SIGNATURE: A. W. Hedrich	24. FUNERAL DIRECTOR: Kott C. & B. M. Walters	ADDRESS: Pratt & Stuckey St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Manchester
LENGTH OF STAY (in this place): 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Manchester, Md.
STREET ADDRESS (If rural give location): Main Street.

3. NAME OF DECEASED (Type or Print): (First) Minnie (Middle) Alice (Last) Cash.

4. DATE OF DEATH: (Month) February (Day) 17 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: July 27, 1880

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Beckleysville Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Stiffler

14. MOTHER'S MAIDEN NAME: Laura C. Bull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: George W. Cash

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Embolism.	3 Days
415 Antecedent cause(s)	(b) Renal Sclerosis.	?
93c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Rheumatic Cardio-Vascular Disease	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 16, 1945 to Feb 14, 1950, that I last saw the deceased alive on Feb 14, 1950, and that death occurred at 10 35 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob E. Bush M.D. Hampstead Md. Feb. 14, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-17-50 — NAME OF CEMETERY OR CREMATORY: Beckleysville Md. — LOCATION (City, town, or county) (State): Beckleysville Balto. Md.

DATE REC'D BY LOCAL REG.: Feb 16/50 — REGISTRAR'S SIGNATURE: Mrs. W. R. P. Dennen

24. FUNERAL DIRECTOR — ADDRESS: Jacob Wm. Bair Manchester, Md.

FEB 20 1950
BUREAU U. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01411

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 24 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) W.	(Last) Carr	4. DATE OF DEATH	(Month) Febr.	(Day) 12	(Year) 1950
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) div. (?)	8. DATE OF BIRTH Aug. 2, 1900	9. AGE last birthday 49 yrs.	If under 1 year Months	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Auburn B. Carr	14. MOTHER'S MAIDEN NAME Emma Agee						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---	16. SOCIAL SECURITY NO. ----	17. INFORMANT Records of Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Intestinal obstruction	6 days
570.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
37b	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Postencephalitic parkinsonism — 27 years

19a. DATE OF OPERATION ----	19b. MAJOR FINDINGS OF OPERATION ----	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) ----	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----	(CITY OR TOWN) (COUNTY) (STATE) ----
TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Febr. 12, 1950, that I last saw the deceased alive on Febr. 11, 1950, and that death occurred at 9,40 a.m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. (Degree or title) — ADDRESS Sykesville, Md. — DATE SIGNED Febr. 12, 1950

Martin Gross, M.D.

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF Feb 12 1950	NAME OF CEMETERY OR CREMATORY Bethesda	LOCATION (City, town, or county) Montgomery Co. (State) Md.
DATE REC'D BY LOCAL REG. Feb. 12, 1950	REGISTRAR'S SIGNATURE C Harry Weer	24. FUNERAL DIRECTOR Robert A. Cumphrey	ADDRESS Bethesda, Md.

99849

RECEIVED
FEB 14 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01412

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH- COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 9 mos. 9 das
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY: Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Reisterstown
STREET ADDRESS (If rural, give location): Liberty Lane

3. NAME OF DECEASED (Type or Print): (First) DANIEL (Middle) (Last) CARTER

4. DATE OF DEATH: (Month) February (Day) 14 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 1, 1889

9. AGE last birthday: 60 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Staunton, Virginia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Carter

14. MOTHER'S MAIDEN NAME: Rebecca ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Pulmonary Tuberculosis — Interval between onset and death: April 20, 1949

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 1949, to Feb. 14, 1950, that I last saw the deceased alive on Feb. 14, 1950, and that death occurred at 2:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M.D. — ADDRESS: Henryton, Md. — DATE SIGNED: 2/14/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2-17-50 — NAME OF CEMETERY OR CREMATORY: St. Lukes Cem. — LOCATION (City, town, or county) (State): Reisterstown, Md.

DATE REC'D BY LOCAL REG. 2/14/50 — REGISTRAR'S SIGNATURE: Albert R. Swankhaus — Deputy Local

24. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home 1631 5208 Druid Hill ave.

RECEIVED
FEB 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01413

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Uniontown R.F.D. 1; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Flora (Middle) Belle (Last) Cartzendafner

4. DATE OF DEATH: (Month) 2 (Day) 20 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): M.

8. DATE OF BIRTH: 10-17-1877

9. AGE last birthday: 72 yrs. If under 1 year: Months. 4 Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Oliver Angel

14. MOTHER'S MAIDEN NAME: Margaret Powe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Jessie Cartzendafner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Occlusion

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to Feb 19, 1950, that I last saw the deceased alive on Feb 19, 1950, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. H. Legg M.D. ADDRESS Union Bridge DATE SIGNED 2-20-50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) B | DATE 2-22-50 | NAME OF CEMETERY OR CREMATORY Church of God | LOCATION (City, town, or county) Uniontown | (State) Md

DATE REC'D BY LOCAL REG. Feb 22, 1950 | REGISTRAR'S SIGNATURE Leslie L. Repp | 24. FUNERAL DIRECTOR Raymond K. Wright | ADDRESS

RECEIVED
FEB 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01414

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (in this place) 55 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near Cedarhurst

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
STREET ADDRESS (If rural, give location) Near Cedarhurst

3. NAME OF DECEASED (Type or Print): (First) Florence (Middle) Virginia (Last) Cowan

4. DATE OF DEATH: (Month) (Day) (Year) Feb. 27, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec. 7, 1879

9. AGE last birthday: 70 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Baltimore Co.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lewis Beltz

14. MOTHER'S MAIDEN NAME: Margaret Jane Helwig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ralph A. Cowan Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d. (b) hypertension + myocarditis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-42 to 2-27-50, that I last saw the deceased alive on 2/26/50, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE James L. Saffell (Degree or title) M. D. ADDRESS Reisterstown Md DATE SIGNED 2-28-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: March 2, 1950

NAME OF CEMETERY OR CREMATORY: Finksburg

LOCATION (City, town, or county) (State): Carroll Co., Md.

DATE REC'D BY LOCAL REG. 2-28-50

REGISTRAR'S SIGNATURE Mary B. Eline. by L. K. Woodward

24. FUNERAL DIRECTOR ADDRESS: J. F. Eline & Sons, Reisterstown, Md.

5206

VS. A15

RECEIVED
MAR 2 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11415

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) since 6/12/39
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 1713 Park Avenue

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) C (Last) DEMING

4. DATE OF DEATH: (Month) February (Day) 8 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 10/30/1871

9. AGE last birthday: 78 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire insurance adjuster

10b. KIND OF BUSINESS OR INDUSTRY: insurance

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Joseph Deming, Sr.

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Records - Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchopneumonia	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

491.8 / 107

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Involutional melancholia with arteriosclerosis — 12 years

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION: ---

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): --- — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: --- — (CITY OR TOWN): --- (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: --- — INJURY OCCURRED While at Work ☐ Not While At work ☐: --- — HOW DID INJURY OCCUR?: ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Feb. 7, 1950, that I last saw the deceased alive on Feb. 7, 1950, and that death occurred at 7:40 A. m., from the causes and on the date stated above.

SIGNATURE Martin Gross, M. D. (Degree or title) — ADDRESS Sykesville, Maryland — DATE SIGNED 2/8/50

Martin Gross, M.D.

23. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify): — DATE THEREOF 2-10-50 — NAME OF ~~CEMETERY~~ OR CREMATORY Greenmount — LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. Feb. 9, 1950 — REGISTRAR'S SIGNATURE C. Harry Weis — 24. FUNERAL DIRECTOR Wm Cook, Inc. — ADDRESS 1217 St. Paul St.

266.80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1950
BUREAU V. S.

Evidence for addition in #18 shown on:

FILM No. G 124 MAR 13 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01416 Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville LENGTH OF STAY (in this place): since 11/2/43	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): 1411 Linden Avenue

3. NAME OF DECEASED (Type or Print)	(First) Thomas	(Middle) Wilson	(Last) DIVEN	4. DATE OF DEATH	(Month) February (Day) 28 (Year) 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: Feb. 6, 1920	9. AGE last birthday: 30 yrs.	If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: ---	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME: Thomas W. Diven		14. MOTHER'S MAIDEN NAME: Agnes Elizabeth Nash			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service): ---	16. SOCIAL SECURITY No.: 214-16-5153	17. INFORMANT AND ADDRESS: Records - Springfield State Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Terminal bronchopneumonia	1 day
193 X Antecedent cause(s)		more than 8 yrs.
54b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Brain tumor; Inoperable glioma (Primary) (3/13/50 - 17 m.S.)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ---	19b. MAJOR FINDINGS OF OPERATION: ---	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---	(CITY OR TOWN) --- (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ ---	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Feb. 27, 1950, that I last saw the deceased alive on Feb. 27, 1950, and that death occurred at 3:07 a.m., from the causes and on the date stated above.

SIGNATURE: Martin Gross, M.D. (Degree or title) Martin Gross, M.D. ADDRESS: Sykesville, Maryland DATE SIGNED: 2/28/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 3/3/50	NAME OF CEMETERY OR CREMATORY: New Cathedral Cem	LOCATION (City, town, or county) (State): Edmondson Ave
DATE REC'D BY LOCAL REG.: 3/1/50	REGISTRAR'S SIGNATURE: A. W. Hedrick	24. FUNERAL DIRECTOR: Chas P. Towell	ADDRESS: 2427 Edmondson Ave

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

Evidence for change of birth date shown on:

01417

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILE No. G 124 FEB 27 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md.
LENGTH OF STAY (in this piece) 21 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Maurice (Middle) (Last) Dorsey

4. DATE OF DEATH (Month) 2 (Day) 14 (Year) 1950

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 4/1 ~~1~~ 1894
9. AGE last birthday 55 yrs. If under 1 year Months Deys If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Prince George's County
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME L. W. Dorsey
14. MOTHER'S MAIDEN NAME Bessie Sencindiver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Springfield State Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
422.2	Immediate cause	(a) Chronic Myocarditis	10 yrs
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause lest	(b) Epilepsy	44 yrs
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1941, to Feb. 14, 1950, that I last saw the deceased alive on Feb. 14, 1950, and that death occurred at 10:12 am., from the causes and on the date stated above.

SIGNATURE W H Martin (Degree or title) M.D. ADDRESS Springfield State Hosp. Sykesville, Maryland DATE SIGNED 2/14/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Feb. 16, 1950
NAME OF CEMETERY OR CREMATORY Green Hill
LOCATION (City, town, or county) (State) Martinsburg, W. Va.

DATE REC'D BY LOCAL REG. Feb. 15, 1950
REGISTRAR'S SIGNATURE C Harry Weer
24. FUNERAL DIRECTOR C H Weer ADDRESS Sykesville Md.

XUX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

FEB 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01418

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks day

Hospital, Institution, or street address where death occurred: Shalls Convalescent Home

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Finebro
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ANNA SEVILLA DUBS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jacob W. Dubs

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 7 1853

8. AGE:

Years	Months	Days	If less than one day
96	3	4	..... hrs. ..... min.

9. Birthplace: York Co. Po
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John W. Hoffacker
13. Birthplace: York Co. Po

MOTHER
14. Maiden name: Anna Maria Cranmer
15. Birthplace: York Co. Po

16. Informant: H. Geiple
Address: Glen Rock Po

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Feb 14 1950
(month) (day) (year)

Cemetery or crematory: Lazarus Union Cemetery

Location: Finebro Md

18. Funeral director: H. Geiple
Address: Glen Rock Po

19. Feb. 13 1950 Mrs W. P. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11 1950, at 2:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1950, to Feb. 11 1950 and that I last saw her alive on Feb 10 1950

Immediate cause of death	DURATION
Uremia	2 weeks
Due to Arterio-Sclerosis	10 years
Due to	
Other conditions	

450.0 (Include pregnancy within 3 months of death)

Major findings of operations

97 Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maurice C. Porterfield
M. D. or other

Address: Hampstead Md Date signed 2/11/50

VS A15 9-45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

RECEIVED
FEB 17 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

61419

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH — COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 18 das.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17 Md,
STREET ADDRESS (If rural, give location): 1221 Madison Ave

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) HAYWOOD (Last) EBRON

4. DATE OF DEATH: (Month) February (Day) 7 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married M

8. DATE OF BIRTH: March 20, 1902

9. AGE last birthday: 47 yrs. — If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oak City N. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Calvin Ebron

14. MOTHER'S MAIDEN NAME: Rozxanna Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-2578

17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Pulmonary Tuberculosis — Interval between onset and death: 1938

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 20, 19 50, to Feb. 7, 19 50, that I last saw the deceased alive on Feb. 7, 19 50, and that death occurred at 6:40 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M. D. — ADDRESS: Henryton Md. — DATE SIGNED: 2/7/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2-11-'50 — NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem. — LOCATION (City, town, or county): Baltimore, (State): Md.

DATE REC'D BY LOCAL REG. 2/7/50 — REGISTRAR'S SIGNATURE: Albert R. Swanbaum — 24. FUNERAL DIRECTOR: Charles H. Alexander — ADDRESS: 1200 McCulloh St., Balt., Md.

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1950
U. S. NAVAL
OBSERVATORY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01420

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: enryton
LENGTH OF STAY (in this place): 4 mos. 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 30
STREET ADDRESS (If rural, give location): 935 Leadenhall St.,

3. NAME OF DECEASED (Type or Print): (First) ELIJAH (Middle) I (Last) FELDER

4. DATE OF DEATH: (Month) February (Day) 26 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept.,26,1922

9. AGE last birthday: 27 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Manning, S.Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Miles Felder

14. MOTHER'S MAIDEN NAME: Jennie Nelosn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mr. Benjamin Felder, 935 Leadenhall St.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — Interval Between Onset and Death: Oct.,1946

0022 Antecedent cause(s)

131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept.,28, 1949., to Feb.,26., 1950, that I last saw the deceased alive on Feb.,26., 1950 and that death occurred at 2:30 A.m., from the causes and on the date stated above.

SIGNATURE: Reuben Hoffman, M.D. (Degree or title)

ADDRESS: Henryton, Maryland

DATE SIGNED: 2/26/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 2/28/50

NAME OF CEMETERY OR CREMATORY: Mt Calvary

LOCATION (City, town, or county) (State): a.a. co., Md

DATE REC'D BY LOCAL REG.: 2/26/50

REGISTRAR'S SIGNATURE: Albert R. Swankhaus

24. FUNERAL DIRECTOR: Isaiah L. Brown & Son

ADDRESS: 1082 W Montgomery St

Deputy Local

RECEIVED
FEB 28 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01421

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown Rural
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) CATHERINE (Last) FOX

4. DATE OF DEATH (Month) Feb (Day) 22 (Year) 1950

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH Aug 12 1870

9. AGE last birthday 79 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY At home

11. BIRTHPLACE (State or foreign country) Frederick County Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME William H. Seabins

14. MOTHER'S MAIDEN NAME Sarah Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT AND ADDRESS Harry O. Fogle, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Myocardial insufficiency	8 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Cardio vascular disease	3 years
	(c)	

422.1
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE James T. Marsh (Degree or title) M.D ADDRESS Westminster Md DATE SIGNED Feb 22-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 2/25/50 NAME OF CEMETERY OR CREMATORY Baust Reformed Cem. LOCATION (City, Town, or county) Union Bridge R.D (State) Md.

DATE REC'D BY LOCAL REG. Feb 25, 1950 REGISTRAR'S SIGNATURE Ethel M Mehring

24. FUNERAL DIRECTOR Powell & Hartzler ADDRESS Woodsboro & Libertytown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 28 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

011422

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville
LENGTH OF STAY (In this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): Unk.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lila	Ann	Foxwell	2	21	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	widowed	May 28, 1885	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Maryland	U.S.A.

13. FATHER'S NAME: Joseph V. Richardson

14. MOTHER'S MAIDEN NAME: Alice Marian Bayne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no			Springfield State Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arter Sclerosis	15 yrs
	(c) Hypertension	

331 X
83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 8/23/45, 19..., to 2/21/, 1950, that I last saw the deceased alive on 2/21/, 1950, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
W. H. Haslam M.D.	Springfield State Hosp. Sykesville, Maryland	2/21/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-24-50	St Michaels	Ridge, St Mary's, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 22, 1950	C. Harry Weir	Wm Cook Inc.	1212 St Paul St. Balto. Md.

BUREAU V. S.
1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01423

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural—Sykesville — LENGTH OF STAY (in this place): 1 yr, 7 mos, 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): 813 West Barre Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	EDWARD	FUNK	2	10	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
M	W	Married	8/1/91	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bartender		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Funk	Nettie Overton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
141 Immediate cause	(a) Metastatic Carcinoma of the tongue	indefinite-
Antecedent cause(s)		more than
45b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	18 months
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 6/30, 1948, to 2/10, 1950, that I last saw the deceased alive on 2/10, 1950, and that death occurred at 7:30 EST A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Henry C. Mead	M. D.	Sykesville, Maryland	2/10/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/13/50	Western Cem.	Balto., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
February 11 1950	R.U.C. W. Deduck	WM. J. TICKNER & SONS	Balto., Md.

7107

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01424

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Margaret	Emma	Green	Feb	10	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	6-6-1874	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
P Hatfield	Lucy P

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		None	Mrs. Brooxxe Wayton, Woodbine, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	4 days
331 X Antecedent cause(s)		
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteria Sclerosis	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 6, 1950, to Feb 10 1950, that I last saw the deceased alive on Feb 9, 1950, and that death occurred at 6 30 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. M. Van Poole M.D.		Mt Airy Md	2/10/50

23. BURIAL, CREMATION / REMOVAL, (Specify)	DATE	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county)	(State)
Burial	2-13-1950	Poplar Springs	Howard Co.	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/11/50	Wm D Snyder	C. M. Waltz	Mt Airy Md

RECEIVED
FEB 13 1950
N. MEXICO

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11425

Reg. Dist. No. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster; LENGTH OF STAY (in this place) 66 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 206 E. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 20 E. Green St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Samuel	D	Helm	2	23	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	Married	Nov. 22-1883	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor Retired	Home Painter	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Beale Helm	Mary Ellen Radcliffe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If year, give war or dates of service)	17. INFORMANT AND ADDRESS
No	220-12-8890	Radcliffe Helm 206 E. Green Westminster, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	5 min.
Antecedent cause(s)		
420.1 94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary artery disease	12 mos +
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Nov 49, to Feb 23, 50, that I last saw the deceased alive on Feb 22, 1950, and that death occurred at 7:15 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T Marsh	M.D.	Westminster Md	2-24-50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-25-1950	Meadow Branch Cem.	Westminster R.D.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/24/50	[illegible]	H Bankard Hon	Westminster Md.

3405

RECEIVED
FEB 27 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75 01426

1. PLACE OF DEATH:

County: Carroll

City or town: Manchester, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: - No

3. (a) FULL NAME: John Christian Hunt

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Laura J. Hunt

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): Nov 8 1863

8. AGE: Years: 86 Months: 3 Days: It less than one day ... hrs. ... min.

9. Birthplace: Carroll County (Town, county, and state)

10. Usual occupation: - Farmer

11. Industry or business

FATHER

12. Name: Christian Hunt

13. Birthplace: Germany

MOTHER

14. Maiden name: Katharina Hirshman

15. Birthplace: Germany

16. Informant: - Carroll Hunt

Address: Greenmount, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 11/50 (month) (day) (year)

Cemetery or crematory: Manchester

Location: Carroll Co Md

18. Funeral director: Edw C Tipton

Address: Hampstead Md

19. Feb. 10 1950 (Date rec'd by registrar) Mrs. H. R. Deaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8 1950, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1948, to Feb 8 1950 and that I last saw him alive on Feb 4 1950

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions: Cerebral hemorrhage	1 yr
331 Decubitus ulcers	4 Mon

(Include pregnancy within 3 months of death)

83a

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. Foard M.D. (M. D. or other)

Address: Manchester, Md Date signed: 2/8/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
FEB 17 1950
BUREAU V. S.

01427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Hampstead — LENGTH OF STAY (in this place): 1 year	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Hampstead
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Alexis	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) ERMA	(Middle) CLARK	(Last) HURT	4. DATE OF DEATH	(Month) Feb (Day) 17 (Year) 1950
5. SEX: F.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 3-24-1918	9. AGE last birthday: 31 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own home	11. BIRTHPLACE (State or foreign country): Md	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: Henry W. Clark	14. MOTHER'S MAIDEN NAME: Sarah Bayer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: —	17. INFORMANT AND ADDRESS: John G. Hurt Hampstead Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

976X Immediate cause (a) Gunshot wound

Antecedent cause(s)

164C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home	(CITY OR TOWN) Alexis (COUNTY) Carroll (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Feb. 17-50 2:45 P.m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? Self inflicted gun shot wound

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 2:45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Thorsh	Deputy Medical Examiner	Westminster Md	Feb. 17-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 2-20-50	NAME OF CEMETERY OR CREMATORY: Glen Haven	LOCATION (City, town, or county) (State): Glen Burnie Md
DATE REC'D BY LOCAL REG.: Feb. 18/50	REGISTRAR'S SIGNATURE: Mrs. H. R. S. Denner	24. FUNERAL DIRECTOR: Jacob Winks Sam Manchester Md	ADDRESS

M

I

VS. A13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

011428

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 5 mos. 27 das.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole, Maryland.
STREET ADDRESS (If rural, give location) Parole Street.

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) ADMIRAL (Last) JOHNSON Jr.
4. DATE OF DEATH: (Month) February (Day) 25, (Year) 1950

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S.
8. DATE OF BIRTH: Dec. 8, 1944
9. AGE last birthday: 5 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Parole, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Johnson
14. MOTHER'S MAIDEN NAME: Margaret Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: (Mother) Margaret Johnson- Parole, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Miliary Tuberculosis — July, 1949

Antecedent cause(s) 019.2

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 220 (b) Tuberculous Menigitis — Sept., 1949

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 28, 19[illegible], to Feb. 25, 1950, that I last saw the deceased alive on February 25 1950, and that death occurred at 12:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Reuben Hoffman, M.D. — Henryton Maryland — 2/25/50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE Feb. 27/50 — NAME OF CEMETERY OR CREMATORY Union — LOCATION (City, town, or county) (State) Davidsonville, Md.

DATE REC'D BY LOCAL REG. 2/25/50 — REGISTRAR'S SIGNATURE Albert R. Swanhaus — 24. FUNERAL DIRECTOR J. B. Johnson — ADDRESS Annapolis, Md.

Deputy Local

RECEIVED
MAR 6 1950
BUREAU V. S.

01429

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 6 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fruitland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) CURTIS	(Middle) EBENEZER	(Last) JONES	4. DATE OF DEATH	(Month) Feb.,	(Day) 1,	(Year) 1950
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Aug. 10, 1922	9. AGE last birthday: 27 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: Hooper Jones, Sr.,	14. MOTHER'S MAIDEN NAME: Amanda Robinson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 215-14-3905	17. INFORMANT AND ADDRESS: Deceased					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — June, 1944

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 26, 1950, to Feb. 1, 1950, that I last saw the deceased alive on Feb., 1, 1950, and that death occurred at 9:20 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Nelson Hoffman, M.D.		Henryton, Maryland	2/1/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 2-5-50	NAME OF CEMETERY OR CREMATORY: Mt. Mt. Calvary	LOCATION (City, town, or county): Fruitland (State): Md.
DATE REC'D BY LOCAL REG.: 2/1/50	REGISTRAR'S SIGNATURE: Albert R. Swankhaus	24. FUNERAL DIRECTOR: Norma J. Ward	ADDRESS: Marion Station Md.

Deputy Local

XUX49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
FEB 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01430

Reg. Dist. No. 34

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Calvert
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Willows
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HELEN	MABLE	JONES	Feb.,	12	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Married	Aug., 13, 1924	25 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house wife		Willows, Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Johnson	Annie Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	February,
0021 Antecedent cause(s)		1949
131 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan., 25, 1950, to Feb., 12, 1950, that I last saw the deceased alive on Feb., 12, 1950, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Maryland	2/12/50

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-14-50	St. Edmonds	Calvert Co	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/12/50	Albert R. Swankhouser Deputy Local	P. E. Sewell	Prince Frederick Md

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 15 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01431 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Henryton
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre De Grace, Md.
STREET ADDRESS (If rural, give location) 734 Otsego St.

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) PERRY (Last) JONES

4. DATE OF DEATH: (Month) February (Day) 16, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S

8. DATE OF BIRTH: Oct. 31, 1909

9. AGE last birthday: 40 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Havre De Grace, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Jones

14. MOTHER'S MAIDEN NAME: Ellen Bowser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: 163-01-2676

17. INFORMANT AND ADDRESS: Mr. William Jones, 734 Otsego St.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Tuberculosis	Nov., 1949
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

002X
13b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1950, to Feb. 16, 1950, that I last saw the deceased alive on Feb. 16, 1950, and that death occurred at 5:55 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Reuben Hoffman, M.D. ADDRESS Henryton, Maryland. DATE SIGNED 2/16/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Feb. 19, 1950
NAME OF CEMETERY OR CREMATORY: St. James Cemetery
LOCATION (City, town, or county) (State): Havre de Grace, Md.

DATE REC'D BY LOCAL REG. 2/16/50
REGISTRAR'S SIGNATURE: Albert R. Smith Deputy Local

24. FUNERAL DIRECTOR ADDRESS: Elmer E. Bullock, 556 Lewis St. Havre de Grace, Md.

75041

RECEIVED
FEB 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01432

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural-Sykesville
LENGTH OF STAY (in this place): 2 mos., 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 9925 Southerland Road

3. NAME OF DECEASED (Type or Print): (First) ROSE (Middle) (Last) KAUFFMAN

4. DATE OF DEATH: (Month) 2 (Day) 17 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1/28/74

9. AGE last birthday: 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Johnston

14. MOTHER'S MAIDEN NAME: Amanda Rahn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Sclerotic disease — Interval Between Onset and Death: Indef

4201 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic C.V. disease

(c) Hypertension C.V. disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Psychosis with cerebral arteriosclerosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/25, 1949, to 2/17, 1950, that I last saw the deceased alive on 2/17, 1950, and that death occurred at 4:55 A EST m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M. D. ADDRESS: Sykesville, Maryland DATE SIGNED: 2/17/50

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation — DATE: Feb. 18 1950 — NAME OF CEMETERY OR CREMATORY: Fort Lincoln — LOCATION (City, town, or county) (State): Hyattsville, Md

DATE REC'D BY LOCAL REG.: Feb. 17, 1950 — REGISTRAR'S SIGNATURE: Nancy Keen

24. FUNERAL DIRECTOR: Warren E. Cumphrey, Inc. — ADDRESS: Silver Spring, Md. V 3441

RECEIVED
FEB 20 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01433

CERTIFICATE OF DEATH

Reg. Dist. No. 7H

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md. — LENGTH OF STAY (in this place) 21 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural, give location) — ✓

3. NAME OF DECEASED (Type or Print)	(First) Elizabeth	(Middle)	(Last) Koch	4. DATE OF DEATH	(Month) 2 (Day) 9 (Year) 1950
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow	8. DATE OF BIRTH 9/26/82	9. AGE last birthday 67 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Frederick Fritzenwangl			14. MOTHER'S MAIDEN NAME Mary Roy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT Springfield State Hospital records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis	6 months
290.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pernicious anemia	21 years
93e	(c) Rheumatoid arthritis and schizophrenia	21 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/15, 1949, to 2/9/, 1950, that I last saw the deceased alive on 2/9/, 1950, and that death occurred at 12:35 p.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Springfield State Hospital Sykesville, Maryland DATE SIGNED 2/9/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2-11-50	NAME OF CEMETERY OR CREMATORY St Mathews Cem.	LOCATION (City, town, or county) (State) Balto. Md.
DATE REC'D BY LOCAL REG. Feb. 10, 1950	REGISTRAR'S SIGNATURE C. Harry Weer	24. FUNERAL DIRECTOR Cole Funeral Home	ADDRESS 1913 W. Balto St.

RECEIVED
FEB 13 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01434

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: "enryton
LENGTH OF STAY (in this place): 1yr. 7mos. 13days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPTTAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 17
STREET ADDRESS (If rural, give location): 1651 N. Fulton Ave.,

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) MAE (Last) LUNN

4. DATE OF DEATH: (Month) February (Day) 12, (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec., 17, 1924

9. AGE last birthday: 25 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Lunn

14. MOTHER'S MAIDEN NAME: Edna Pauley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Pulmonary Tuberculosis — Interval Between Onset and Death: April, 1948

Antecedent cause(s): 1948

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

(c):

0021 X

131-

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 30, 19 50, to Feb., 12, 19 50, that I last saw the deceased alive on Feb., 12, 19 50, and that death occurred at 9:10 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben W Braun, M.D.

ADDRESS: "enryton, Maryland

DATE SIGNED: 2/12/50

23. BURIAL, CREMATION, REMOVAL (Specify): Buried

DATE: 2-16-1950

NAME OF CEMETERY OR CREMATORY: Arbutus Cem.

LOCATION (City, town, or county) (State): Balto Co. Md.

DATE REC'D BY LOCAL REG. 2/12/50

REGISTRAR'S SIGNATURE: Albert R. Swanhaus

24. FUNERAL DIRECTOR: Mrs Kathe P. Wadlund

ADDRESS: 322 N. Schroeder St

Deputy Local

RECEIVED
FEB 15 1950
BUREAU V. S.

01435

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

BC

Reg. Dist. No. 74

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural: Sykesville — LENGTH OF STAY (in this place): 7 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore — 29
STREET ADDRESS (If rural give location): 715 Denison Street

3. NAME OF DECEASED (Type or Print) (First) LENA (Middle) ELIZABETH (Last) ENGLE MACKEY

4. DATE OF DEATH (Month) Febr. (Day) 26 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: 11/30/98
9. AGE last birthday: 51 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ENGLE
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital records, Sykesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

002x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

13b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Involutional psychosis depressed type — "

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1949, to Feb 26, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE: Henry C. A. Mead, M.D. (Degree or title) — ADDRESS: Sykesville Md — DATE SIGNED: 2/26/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 2/1/50 — NAME OF CEMETERY OR CREMATORY: Balto Nat. — LOCATION (City, town, or county) (State): 5400 Frederick Rd

DATE REC'D BY LOCAL REG.: 2/28/50 — REGISTRAR'S SIGNATURE: H. W. Hedrick — 24. FUNERAL DIRECTOR: Harry H Witzke — ADDRESS: 4101 Edmondson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01436

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LELIA	MAY	MARTIN	February	14	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Separated	1-19-1900	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Convulsion	Minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General paresis about	7 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 5:10 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James T. Marsh	Deputy Medical Examiner	Westminster, Md	Feb 15, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-21-50	Springfield	Sykesville, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 21, 1950	C. Harry Ward	C. H. Ward - Sykesville, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01437

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY: Carroll; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton; LENGTH OF STAY (in this place): 7mos. 11days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: ; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 1; STREET ADDRESS (If rural, give location): 586 Oxford St.,

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	EARLE		MC KNIGHT		Feb.,	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Widowed	Feb.,15,1903	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Sumter, S. Caroline	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Eli Mc Knight	Luvinia Couser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No		None	Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tubefculosis of Spine	Mar.,1949
012,0 Antecedent cause(s)		
16 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 24, 1949 to Feb., 5, 1950, that I last saw the deceased alive on Feb., 5, 1950, and that death occurred at 7:05 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.	Henryton, Md.	2/5/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-8-50	Mt. Calvary	Balto.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/5/50	Albert R. Swankhamer Deputy Local	William A. Jackson	916 Penna ave Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

D1438

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sandimingo
STREET ADDRESS (If rural, give location): Rt. I Box 98 Mardela Springs P.O.

3. NAME OF DECEASED (Type or Print): (First) RUFUS (Middle) ELZY (Last) MOORE
4. DATE OF DEATH: (Month) February (Day) 11, (Year) 1950

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: October 16, 1893
9. AGE last birthday: 56 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sharptown, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Tommy Moore
14. MOTHER'S MAIDEN NAME: Janie Polk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-12-4682
17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Pulmonary Tuberculosis — Interval between onset and death: October, 1948

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 26, 1950 to Feb. 11, 1950, that I last saw the deceased alive on Feb. 11, 1950, and that death occurred at 7:10 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben Hoffman, M-D. — ADDRESS: Henryton, Md. — DATE SIGNED: 2/11/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-14-50 — NAME OF CEMETERY OR CREMATORY: Sharptown — LOCATION (City, town, or county) (State): Sharptown, Md.

DATE REC'D BY LOCAL REG. 2/11/50 — REGISTRAR'S SIGNATURE: Albert R. Swankhaus — 24. FUNERAL DIRECTOR: J. J. Frampton - Fredenburg, Md. — ADDRESS

Deputy Local

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A16

RECEIVED
FEB 15 1950
BUREAU V. S.

01439

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster — LENGTH OF STAY (in this place): 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 17 Westmoreland Street

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westminster
STREET ADDRESS (If rural, give location): 17 Westmoreland Street

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) A (Last) Nagle
4. DATE OF DEATH: (Month) Feb. (Day) 2 (Year) 1950
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Feb. 7-1890
9. AGE last birthday: 59 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Ward
14. MOTHER'S MAIDEN NAME: Jane Murry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Harry E. Nagle 17 Westmoreland St Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X Immediate cause (a) Cerebral hemorrhage — 2-1-50

Antecedent cause(s) — 2-2-50

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 12 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950, to 2-2-, 1950, that I last saw the deceased alive on 2-2-, 1950, and that death occurred at 4:25 P m., from the causes and on the date stated above.

SIGNATURE: W. C. Jennette MD (Degree or title) — ADDRESS: Westminster Md. — DATE SIGNED: 2-3-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb. 4-1950 — NAME OF CEMETERY OR CREMATORY: Westminster Cemetery — LOCATION (City, town, or county): Church St. Westminster, Md. (State)

DATE REC'D BY LOCAL REG.: 2/3/50 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: H Bankard & Son Westminster, Md. — ADDRESS

M

I

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 6 1950
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

01440

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS N. Center St. Sta 1

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) N. Center St. Sta 1

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harry	Ambrose	Husbaum	Feb.	18	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
M	W	Married	Aug. 11-1890	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farming	Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lee Husbaum	Ellen Byers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes World War I	214-16-0040	Edna Husbaum

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Dislocated cervical Vertebra

9748 Antecedent cause(s)

1640 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hanging by the neck

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
Suicide	Home	Westminster	Carroll	Md.

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR?
Feb. 18-1950 / 1 p.m.		Hanged self

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 1:15 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James F. Mosser	Deputy Medical Examiner	Westminster Md	Feb 20/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 21-1950	Meadow Branch Cem.	Westminster, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/20/50	[signature]	H. Bankard Son	Westminster Md.

98099

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

RECEIVED
FEB 23 1950
BUREAU V. S.

01441

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Sykesville
LENGTH OF STAY (in this place) 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BERTHA (Middle) — (Last) ORME

4. DATE OF DEATH (Month) 2 (Day) 7 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 1871
9. AGE last birthday 78 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Frederick, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Smith
14. MOTHER'S MAIDEN NAME Martha Ricketts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Records, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypertensive cardiovascular disease	Indefinite
170X Antecedent cause(s)		
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Cardiovascular disease	"
	(c) Carcinoma (scirrhus) right breast	"

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis, agitated "

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/7, 1949, to 2/7, 1950, that I last saw the deceased alive on 2/7, 1950, and that death occurred at 3:40 A m., from the causes and on the date stated above.

SIGNATURE Henry C. McLeod (Degree or title) M. D. ADDRESS Sykesville, Maryland DATE SIGNED 2/7/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-10-50
NAME OF CEMETERY OR CREMATORY Monacacy
LOCATION (City, town, or county) (State) Beallesville, Md.

DATE REC'D BY LOCAL REG. Feb. 7, 1950
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Wm B. Hilton - Barnesville, Md. ADDRESS

RECEIVED
FEB 8 1950
BUREAU V. S.

01442
74

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville — LENGTH OF STAY (in this place) 27 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Piney Grove
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Emma	(Middle) Viola	(Last) Price	4. DATE OF DEATH	(Month) 2	(Day) 17	(Year) 1950
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH March 1895	9. AGE last birthday 54 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James H. Price	14. MOTHER'S MAIDEN NAME Nancy Elvin						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service) ?	16. SOCIAL SECURITY NO. None	17. INFORMANT Springfield State Hospital records					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
353.3	Immediate cause	(a) Cerebral hemorrhage	1 week
95c	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epilepsy	40 years
		(c) Cardiac hypertrophy	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug., 1941, to Feb. 17, 1950, that I last saw the deceased alive on Feb. 16, 1950, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H. J. Martin	M.D.	Sykesville Md	Feb 17-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2-19-50	NAME OF CEMETERY OR CREMATORY Piney Plains Meth. Cem.	LOCATION (City, town, or county) Allegany Co.	(State) Md.
DATE REC'D BY LOCAL REG. 2/18-50	REGISTRAR'S SIGNATURE J. A. Heller C. Harry Weir	24. FUNERAL DIRECTOR Charles R. Bast	ADDRESS Hancock, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 23 1950
BUREAU V. S.

01443

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Sykesville — LENGTH OF STAY (in this place): 3 mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural give location): 1716 South Charles St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): MARTHA MARIE RIEDEL	4. DATE OF DEATH (Month) (Day) (Year): Feb 13 1950
5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow	8. DATE OF BIRTH: 3/29/83 — 9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Home	11. BIRTHPLACE (State or foreign country): Savage, Maryland — 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel Smith	14. MOTHER'S MAIDEN NAME: Ruth Kale
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial insufficiency — few weeks

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pulmonary edema

(c)

422.1

30c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, Syphilis of the C.N.S. — many years

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 7, 1949, to Feb. 13, 1950, that I last saw the deceased alive on Feb 13, 1950, and that death occurred at 2:05 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED: Henry C. A. Mead M.D. Sykesville, Md. 2/13/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/16/50	- Savage Cem.	Savage, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/15/50	H.W. Hedrick Dr	WM. J. TICKNER & SONS	Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

026

I

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01444

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George W. Slonaker

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Emma Myerly Slonaker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1857

8. AGE: Years	Months	Days	If less than one day
92	6	29	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired marble yard operator

11. Industry or business

FATHER
12. Name Jacob Slonaker
13. Birthplace Md.

MOTHER
14. Maiden name Mary Stauffer
15. Birthplace

16. Informant Mrs. William E. Caylor
Address Uniontown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5, 1950 (month) (day) (year)

Cemetery or crematory Church of God

Location Uniontown, Md.

18. Funeral director C.O.Fuss & Son
Address Taneytown, Md.

19. Feb. 4 1950 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1950, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1950, to Feb. 3 1950 and that I last saw him alive on Feb 1 1950

Immediate cause of death Generalized Arteriosclerosis

Due to

Due to

Other conditions

450.0
(Include pregnancy within 3 months of death)

97

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Sharp M.D. M. D. or other

Address Westminster Md Date signed 2/3/50

1882.4

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 7 1950
BUREAU V. S.

01445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Union Mills
LENGTH OF STAY (in this place) ONE MONTH
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Union Mills
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) ANNIE (Middle) RUTH (Last) SMITH

4. DATE OF DEATH (Month) February (Day) 19 (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 5-16-1893
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Shildt
14. MOTHER'S MAIDEN NAME Anna May Gilbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mr Claude Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary Thrombosis	3 hrs.
	Antecedent cause(s)		
94a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 25, 1949, to Dec 27, 1949, that I last saw the deceased alive on Feb 1, 1950, and that death occurred at 1:15p m., from the causes and on the date stated above.

SIGNATURE Maurice C. Porterfield (Degree or title) M.D. actng Med. Exam. ADDRESS Hampstead, Md DATE SIGNED 2-19-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2-23-50
NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery
LOCATION (City, town, or county) Taneytown (State) Maryland

DATE REC'D BY LOCAL REG. 2/21/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR C. O. Fuso & Son Taneytown ADDRESS Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01446

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Pr. George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton — LENGTH OF STAY (in this place): 6 mos. 5 das.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bladensburg,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL	STREET ADDRESS (If rural, give location): 4702 Upshur Street

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): THEODORE ROOSEVELT SMITH	4. DATE OF DEATH (Month) (Day) (Year): February 8 1950
5. SEX: Male — 6. COLOR OR RACE: Negro — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M	8. DATE OF BIRTH: May 3, 1907 — 9. AGE last birthday: 42 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor — 10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Shadyside, Maryland — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Will Smith	14. MOTHER'S MAIDEN NAME: Rachel Foots
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service) — 16. SOCIAL SECURITY No.: 218-01-8439	17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — May, 1949

002 Antecedent cause(s)

13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 3, 1949, to Feb. 8, 1950, that I last saw the deceased alive on Feb, 8, 1950, and that death occurred at 4:50 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Reuben Hoffman, M.D.		Henryton Md.	2/8/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 12-1950	Franklin Teme	Churchton	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/8/50	Albert N. Swankhaus	T. H. Hardesty & Son	

Deputy Local

Galesville, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 15 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01447

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Marriottsville; LENGTH OF STAY (in this place) 2 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS; MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Marriottsville; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) NINA (Middle) L. (Last) SPARKS

4. DATE OF DEATH: (Month) Feb (Day) 8 (Year) 1950

5. SEX F. | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 2-1-1905 | 9. AGE last birthday 45 yrs. | If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME ?— Ashley | 14. MOTHER'S MAIDEN NAME Carrie Caple

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service) — | 16. SOCIAL SECURITY NO. none | 17. INFORMANT AND ADDRESS Mr. Joseph Sparks - Marriottsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fractured skull -

900.0 Antecedent cause(s)

186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fell down cellar steps

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / ~~SUICIDE~~ / HOMICIDE (Specify) Accident | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home | (CITY OR TOWN) Marriottsville | (COUNTY) Carroll | (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) 2 - 8 50 5:45 p.m. | INJURY OCCURRED While at Work ☒ Not While At work ☐ | HOW DID INJURY OCCUR? Fell down cellar steps

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE James F. Monk (Degree or title) Deputy Medical Examiner | ADDRESS Westminster Md | DATE SIGNED Feb 8/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 2-10-50 | NAME OF CEMETERY OR CREMATORY Springfield | LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REG. Feb. 9, 1950 | REGISTRAR'S SIGNATURE C. Harry Weer | 24. FUNERAL DIRECTOR C. H. Weer | ADDRESS Sykesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01448

CERTIFICATE OF DEATH

BC

Reg. Dist. No.

1. PLACE OF DEATH · COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sykesville — LENGTH OF STAY (In this place): since 8/30/26	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): 1325 Greenmount Avenue

3. NAME OF DECEASED (Type or Print)	(First) Joseph	(Middle) ---	(Last) STEVENSON	4. DATE OF DEATH (Month) (Day) (Year) February 1 1950
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: unknown	9. AGE last birthday: 63 ? yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: ---	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME: unknown		14. MOTHER'S MAIDEN NAME: unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If year, give war or dates of service): ---	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT AND ADDRESS: Records - Springfield State Hospital		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause	(a) Cerebral hemorrhage	4 days
Antecedent cause(s)		
30g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	17 years
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with constitutional psychopathic inferiority, plus syphilis.	24 years

19a. DATE OF OPERATION: ---	19b. MAJOR FINDINGS OF OPERATION: ---	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---	(CITY OR TOWN) (COUNTY) (STATE): ---
TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.	INJURY OCCURRED --- While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Sept. 1, 1947, to Feb. 1, 1950, that I last saw the deceased alive on Feb. 1, 1950, and that death occurred at 9:20 A. m., from the causes and on the date stated above.

SIGNATURE: Martin Gross, M. D. (Degree or title) — Martin Gross, M.D.

ADDRESS: Sykesville, Maryland

DATE SIGNED: 2/1/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY: University of Md.	LOCATION (City, town, or county) (State): Anatomy Board
DATE REC'D BY LOCAL REG. 2-6-50	REGISTRAR'S SIGNATURE: A. H. Hedrich	24. FUNERAL DIRECTOR: University of Md. Medical School	ADDRESS

M.K.G.

98899

029

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

11449

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 19 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bel Air
STREET ADDRESS (If rural, give location): Lee Street

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) (Last) SWANN

4. DATE OF DEATH: (Month) February (Day) 21, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Sep.

8. DATE OF BIRTH: July 22, 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Garge Attendent

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Morton Swann

14. MOTHER'S MAIDEN NAME: Anna (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 234-32-0851

17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Tuberculosis	August, 1949
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

002X

13b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2, 1950, to Feb. 21, 1950, that I last saw the deceased alive on Feb. 21, 1950, and that death occurred at 3 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Reuben W. Bowman, M.D. ADDRESS: Henryton, Md. DATE SIGNED: 2/21/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 2/24/50 | NAME OF CEMETERY OR CREMATORY: Bel Air | LOCATION (City, town, or county): Belair (State): Md

DATE REC'D BY LOCAL REG. 2/21/50 | REGISTRAR'S SIGNATURE: Albert R. Swankhaus, Deputy Local | 24. FUNERAL DIRECTOR: Foster Funeral Home - Belair, Md. ADDRESS:

416 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415

RECEIVED
MAR 8 1950
BUREAU V. S.

01450

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH · COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville — LENGTH OF STAY (in this place): 5 yrs. 10 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): 767 W. Lexington St. ✓

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) BERNARD (Last) WARD

4. DATE OF DEATH: (Month) 2 (Day) 17 (Year) 1950

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1-18-13

9. AGE last birthday: 37 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Ward

14. MOTHER'S MAIDEN NAME: Nora Sappington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

979 X Immediate cause (a) Second-third degree burns

Antecedent cause(s) (b) of chest neck and head — 6 wks

164g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with convulsive disorder, epileptic deterioration and D.T.'s.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Springfield State Hosp. (CITY OR TOWN) Sykesville (COUNTY) Carroll (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 26 1949 m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Poured lighter fluid over clothing and set it on fire

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 7:15 P m., from the causes and on the date stated above.

SIGNATURE: James T. Morrell (Degree or title) Deputy Medical Examiner — ADDRESS: Westminster Md — DATE SIGNED: Feb. 18 - 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb. 21 - 1950 — NAME OF CEMETERY OR CREMATORY: New Cathedral — LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG.: 2/20/50 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Mamie C. Syfer — ADDRESS: 1600 W. North ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01451

CERTIFICATE OF DEATH

Reg. Dist. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place) 9 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 155 E. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 155 E. Main St.

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Belle (Last) Weller

4. DATE OF DEATH: (Month) 2 (Day) 17 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept. 9-1872

9. AGE last birthday: 72 yrs. — If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jesse Wagner

14. MOTHER'S MAIDEN NAME: Sarah Jane Babylon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY NO. (If year, give war or dates of service): None

17. INFORMANT AND ADDRESS: Harry Weller 155 E. Main Westminster Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral hemorrhage	4 days
331 Antecedent cause(s)	(b) Arteriosclerosis & hypertension	15 years or more
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. A severe stroke occurred in 1941 and led to marked mental impairment — 9 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1940 to Feb 16, 1950 that I last saw the deceased alive on Feb 16 1950 and that death occurred at 6 A.m., from the causes and on the date stated above.

SIGNATURE: Elsie Wilkens (Degree or title) ADDRESS: Westminster Md DATE SIGNED: Feb 17 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Feb. 19-1950 — NAME OF CEMETERY OR CREMATORY: Meadow Branch Cem. — LOCATION (City, town, or county) (State): Westminster Md.

DATE RECD BY LOCAL REG. 2/19/50 — REGISTRAR'S SIGNATURE: H Bankard

24. FUNERAL DIRECTOR: H Bankard & Son — ADDRESS: Westminster Md.

RECEIVED
FEB 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01452

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (in this place) 5 yr. 10 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural, give location) 7 East Baltimore St. ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Augusta	Lizette	Wendeler	2	27	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	Widow	July 28, 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Picard
14. MOTHER'S MAIDEN NAME: Augusta Ufer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT: Springfield State Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 wk
331 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 830	(b) Arteriosclerosis	1 yr
	(c) Hypertension	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/5, 1947, to 2/27/, 1950, that I last saw the deceased alive on 2/26/, 1950, and that death occurred at 5:00 a.m., from the causes and on the date stated above.

SIGNATURE M. K. Austin (Degree or title) MD ADDRESS Springfield State Hospital, Sykesville, Maryland DATE SIGNED 2/27/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 2 1950	Rose Hill Cemetery	Hagerstown, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 28 1950	C. Stacy Hess	Fred W. Kraiss,	Hagerstown, Maryland

VS. A15

RECEIVED
MAR 3 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01453

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
COUNTY: Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Henryton
LENGTH OF STAY (in this place): 8mos. 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore 23,
STREET ADDRESS (If rural, give location): 413 N. Carey St., ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOHN	FRANK	WILSON	Feb.,	5	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
Male	Negro	Married	Nov., 24, 1905	44 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sand Blaster
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gastonia, N. Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Wilson
14. MOTHER'S MAIDEN NAME: Minnie Riddle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-01-4439
17. INFORMANT AND ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Tuberculosis	January 1, 1949
Antecedent cause(s)	(b)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

002 X 13b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 23, 1949, to Feb., 5, 1950, that I last saw the deceased alive on Feb., 5, 1950, and that death occurred at 1:45 P. m., from the causes and on the date stated above.

SIGNATURE: Reuben Hoffman, M.D. (Degree or title) — ADDRESS: Henryton, Md. — DATE SIGNED: 2/5/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-9-50	Mt. Auburn Cem.	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/5/50	Albert R. Swankhouse	Chas J. Cooper	512 N. Carrollton ave

Deputy Local

496 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1950
BUREAU V. S.